CHILDREN'S ADVANTAGE NEW CLIENT INFORMATION FORM

Client #:
Therapist:

Client Name:_____DOB:_____

Address (Street, City, Zip):_____

Primary Phone #: _____SSN: _____Gender: _____

IF CHILD IS UNDER THE AGE OF 18 - VERIFICATION OF LEGAL RIGHT TO CONSENT (GUARDIANSHIP)

Legal Guardian Name(s)/Relation:_____

_____

_____

Relationship to child (***MUST provide documentation*)***

☐ Biological/Adoptive Mother ☐ Biological/Adoptive Father ☐ Grandmother* ☐ Grandfather* ☐ Aunt*

☐ Uncle*☐ SCCS* ☐ Other (specify i.e. POA, sibling, etc)*
_____

Has the child ever previously been in legal custody of any Children Services Board? ☐ yes ☐ no

If YES, when and where? ***MUST provide documentation*** _____

Name of biological/adoptive mother:_____Phone:_____

Name of biological/adoptive father:_____Phone:_____

Were parents married at the time of the child's birth? ☐ yes ☐ no

If YES, are parents still married? ☐ yes ☐ no

If NO, when and where were parents divorced? _____
MUST provide documentation *(indicate if parent is deceased)*

GENERAL CONSENT FOR SERVICES

☐ **I consent for Children's Advantage to conduct an assessment and to provide mutually agreed upon, medically necessary services.**

I have received an explanation about the risks and the benefits of any proposed services, alternative services and of having no services at all.

I have received a copy of the Clients Rights Summary, HIPAA Privacy Policies and Children's Advantage No-Restraint Policy and have had the opportunity to review them.

Client signature (required if 14 or older): Date:

Signature of Legal Guardian (if client is under the age of 18): Date:

Clients Name: _____ Today's Date:_____

CLIENT DEMOGRAPHICS

RACE ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Middle Eastern ☐ Multiracial ☐ Natie Hawaaiian/Other Pacific Islander ☐ Other ☐ White ☐ Decline

ETHNICITY ☐ Cuban ☐ Hispanic/Latino ☐ Mexican ☐ Native American ☐ Nonhispanic/Latino ☐ Puerto Rican ☐ Decline

MARITAL STATUS ☐ Single ☐ Married ☐ Life Partner/Significant Other ☐ Separated ☐ Divorced ☐ Widowed

RELIGIOUS AFFILIATION ☐ Catholic ☐ Islam ☐ Jewish ☐ Protestant ☐ Other:_____ ☐ Decline

TOBACCO USE ☐ Never Smoked ☐ Current smoker ☐ Former smoker ☐ Unknown if ever smoked

PRIMARY LANGUAGE ☐ English ☐ Other:_____ ☐ Additional Language: _____

EDUCATION (Check highest level completed) ☐ Elementary ☐ Middle School ☐ High School ☐ College ☐ Trade Training

EMPLOYMENT STATUS ☐ Full time ☐ Part time ☐ Disabled ☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed

ADULTS AND CHILDREN LIVING IN OR OUTSIDE THE HOME (INCLUDE MOTHER AND/OR FATHER)

1. _____ Relationship:_____ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A
2. _____ Relationship:_____ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A
3. _____ Relationship:_____ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A
4. _____ Relationship:_____ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A
5. _____ Relationship:_____ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A

EMERGENCY CONTACT: Name:_____ Relationship to Client::_____
Phone:_____ ☐ Cell ☐ Home

CURRENT SYMPTOMS: Please check any of the following which have been a problem or concern in the past 2-4 months

Behavioral	**Emotional**	**Stressors**	**Physical**
☐ Oppositional/Argumentative	☐ Loss Of Pleasure/Interests	☐ Work/School Conflicts	☐ Headaches
☐ Destruction Of Property	☐ Sleeping Problems	☐ Domestic Violence	☐ Vision/Hearing
☐ Lying/Stealing	☐ Nightmares	☐ Divorce/Separation	☐ Swallowing
☐ Aggressive Towards Others	☐ Unusual Tiredness	☐ Grief/Loss	☐ Dental
☐ Angry/ Hurting Others	☐ Appetite/Eating Problems	☐ Peer Relations	☐ Chest Pain/Breathing
☐ Thoughts Of Harming Self/Others	☐ Sadness	☐ Poor Self-Esteem/Image	☐ Nausea/Constipation
☐ Hyperactive/Impulsive	☐ Tearfulness	☐ Major Illness Of Client/Family	☐ Diarrhea/Soiling
☐ Memory Problems	☐ Anxiety/Nervousness	☐ Legal Problems/Probation	☐ Abdominal Pain
☐ Odd / Troubling Thoughts	☐ Panicky/Panic Attacks	☐ Restraining/Protection Order	☐ Back Pain
☐ Hearing Voices Seeing Things	☐ Withdrawn/Isolated	☐ Csb/Court-Ordered Counseling	☐ Genital Pain/Sores
☐ Other	☐ Loneliness	☐ Experienced/Witnessed Trauma	☐ Frequent Infections
	☐ Sexual Concerns	☐ Absent Incarcerated Parent	☐ Coordination/Numbness
	☐ Alcohol/Drug Use	☐ Dependent Family Member	☐ Fainting Spells
	☐ Other	☐ Change In Home/School Setting	
		☐ Other	

CLIENT MEDICAL/BIRTH INFORMATION

Primary Care Physician: _____ Phone: _____

Date Of Last Physical Exam: _____ Allergies ☐ No ☐ Yes ☐ Explain:

_____

Current Medications _____ Current Medications _____

Name Date Reason *Name Date Reason*

Past Medications _____ Past Medications _____

Name Date Reason *Name Date Reason*

Does the client have any physical disabilities? ☐ no ☐ yes ☐ explain:

_____

Does the client have any developmental disabilities? ☐ no ☐ yes ☐ explain:

_____

Does the client have a history of head injury? ☐ no ☐ yes ☐ explain:

_____

Does the client have a history of alcohol and drug abuse or use? ☐ no ☐ yes ☐ explain:

_____

Is there a family history of alcohol / drug abuse abuse? ☐ no ☐ yes ☐ explain:

_____

Is there a blood relative history of major disease or illness? ☐ no ☐ yes ☐ explain:

_____

Is there a family history of suicide? ☐ no ☐ yes ☐ explain:

_____

Is client a victim of sexual or physical abuse? ☐ no ☐ yes ☐ explain:

_____

IF CLIENT IS UNDER AGE 18 PLEASE ANSWER THE FOLLOWING QUESTIONS:

Significant problems with pregnancy or delivery of your child? ☐ no ☐ yes ☐ explain:

_____

Did the biological mother use drugs or alcohol during pregnancy? ☐ no ☐ yes ☐ explain:

_____

Has your child ever been pregnant? ☐ no ☐ yes

Do you have concerns about your child being sexually active? ☐ no ☐ yes

Child development milestones were; ☐ early ☐ on time ☐ delayed

How many times has your child moved for residents from birth to present?_____

Clients Name: _____ Today's Date:_____

DESCRIBE CLIENT INVOLVEMENT

In The Home: _____

Community Supports (Church, Aa, Mentoring Programs): _____

Peer Relationships :_____

Hobbies/Interests/Recreational Activities :_____

Work If Applicable: _____

INVOLVEMENT IN OTHER AGENCIES

Please list any other agencies currently involved with you or your family

Agency/Person_____ Date of Involvment_____

SUMMARY OF NEEDS Please tell us your main reasons for seeking counseling

_____

SOURCE OF REFERRAL ☐ School Staff ☐ Family Friend ☐ Court ☐ County Children Services Board ☐ Self

☐ Akron Children's Hospital ☐ Family Physician ☐ Internet ☐ Community Event ☐ Other